DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185217	A. BUILDING _____ B. WING _____	C 03/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METCALFE HEALTH CARE CENTER	701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129

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F 000	INITIAL COMMENTS An abbreviated standard survey (KY15993) was conducted on March 23-24, 2011. The allegation was substantiated. Deficient practice was identified at a 'G' level, with an opportunity to correct.	F 000	The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide services in accordance with each resident's plan of care for one of three sampled residents (resident #1). The facility failed to utilize a mechanical lift to transfer resident #1 for bathing on February 20, 2011, in accordance with the resident's plan of care, resulting in pain and injury to the resident's right knee. Resident #1 was diagnosed with a fracture to the right tibia and fibula (below the right knee) on February 22, 2011. The findings include: A review of the medical record for resident #1 revealed the resident was admitted to the facility on October 6, 2004, with diagnoses that included severe Osteoporosis, Osteoarthritis, a history of Fractured Vertebrae, and Lumbar Compression. A review of resident #1's annual Minimum Data Set (MDS) dated April 8, 2010, revealed the	F 282	1. Resident #1 received treatment at the hospital upon verification of the x-ray results. An investigation into the circumstances of the injury to Resident #1 was conducted by the Administrator and DON upon identification of the injury findings, with notification of DCBS and the OIG. Review of the status of Resident #1 was conducted with the family, with review/revision of the care plan and patient record to include bed baths for bathing and mechanical lift for all transfers. 2. All residents requiring the use of a mechanical lift have been evaluated to determine appropriate lift use. Findings were reviewed with the residents/families with review/revision of the care plans and patient care records to address lift use as indicated. 3. Licensed and non-licensed nursing staff have received in-service education on the provision of transfer assistance for residents in accordance with the care plan and patient care record, including but not limited to the proper use of the mechanical lift, as provided by the DON/ADON/Staff Development on 2/24, 3/2, 3/7, 3/16, 3/21, 3/23, 3/24, 3/25, 3/26, 3/27, 3/28, 3/30, 3/31, and 4/6.	4/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Mary Neighbors, administrator 4/11/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 facility assessed resident #1 to require total assistance of two or more staff persons for transfers. A review of the resident's comprehensive care plan revealed on April 5, 2010, an intervention for the use of a Hoyer lift for all transfers was added to the resident's plan of care. A review of the Certified Nurse Aide (CNA) Care Plan record for February 2011 revealed two staff persons were to use a mechanical lift for all transfers for resident #1. A review of nurse's notes dated February 22, 2011, at 12:45 p.m., revealed resident #1 was yelling in pain and was noted to have redness and edema to the right leg and right knee. The physician and responsible party were notified and orders were received to transfer resident #1 to the hospital for evaluation and treatment. Resident #1 returned to the facility on February 22, 2011, at 4:30 p.m. Review of the hospital record revealed resident #1 was diagnosed with fractures of the bones to the right leg. A review of the facility's investigation regarding resident #1's fractures dated February 23, 2011, revealed the facility had determined resident #1's leg was injured during a transfer conducted by CNAs #1, #2, and #3 when the CNAs did not use a Hoyer lift to transfer the resident. The resident was reported to state, "Oh, my knee," when the three CNAs transferred resident #1 without the use of a lift on February 20, 2011. An interview conducted with CNA #1 on March 23, 2011, at 2:35 p.m., revealed on February 20, 2011, CNA #3 requested assistance from CNA #1 and CNA #2 to transfer resident #1 to a lift chair for bathing. CNA #1 stated a sitting transfer with the use of a gait belt from a geri-chair to a bath	F 282	4. Observations of non-licensed nursing staff implementation of interventions in accordance with the care plan/patient record will be completed by the DON/ADON/Staff Development Coordinator on 2 staff per day x 1 week, then 2 staff per week x 2 weeks, and then using the CQI Indicator as outlined. The CQI Indicator for the monitoring of implementation of interventions in accordance with the care plan/patient care record will be utilized monthly x 2 months, and then quarterly as per the established CQI calendar, under the supervision of the Director of Nursing.	

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F 282	Continued From page 2	F 282		

chair/lift was completed for resident #1 with the assistance of CNAs #1, #2, and #3. During the transfer resident #1 was noted to complain by saying, "Oh, my knee." However, the resident did not complain at any other time or when the resident was transferred back to the geri-chair after the bath was complete. Additional interview with CNA #1 revealed this method of transfer was always utilized for resident #1 for bathing and that a Hoyer lift was utilized for all other transfers for resident #1.

An interview conducted on March 23, 2011, at 2:48 p.m., with CNA #3, whose primary duty was to bathe residents, revealed on February 20, 2011, CNA #3 requested the assistance of CNAs #1 and #2 to transfer resident #1 from a geri-chair to a bath/lift chair for bathing. CNA #3 stated a gait belt and three-person assist was utilized to transfer the resident. CNA #3 was not aware of any complaints from resident #1 during the transfer. CNA #3 was aware resident #1 was assessed to require a mechanical lift for all transfers. However, staff had never utilized a Hoyer lift when transferring resident #1 for bathing. CNA #3 stated the lift could be utilized but the shower room was small and resident #1 had always been transferred with the use of three staff persons.

An interview conducted with CNA #2 on March 23, 2011, at 3:06 p.m., revealed on February 20, 2011, CNAs #1, #2, and #3 transferred resident #1 from a geri-chair to a bath/lift chair by utilizing a gait belt. CNA #2 stated when resident #1 was turned during the transfer resident #1 said, "Oh, my knee." CNA #2 stated resident #1 had no further complaints after the transfer, during the bath, or when transferred after the bath was

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F 282	Continued From page 3 completed. CNA #2 reported a Hoyer lift had never been utilized for resident #1 during bathing transfers. An interview conducted with LPN #1 on March 23, 2011, at 1:50 p.m., revealed that a lift was required to be utilized when transferring resident #1 because the resident was dead weight and pulling on the resident may hurt the resident. LPN #1 made rounds each shift to monitor bathing and ensure resident care was provided according to each resident's plan of care. However, the LPN was not aware staff was not utilizing a lift to transfer resident #1 for bathing. LPN #1 became aware staff was not utilizing a lift for transferring resident #1 during bathing on February 20, 2011, when the CNAs requested that an order be obtained for showers instead of a tub bath for resident #1 because of the resident's size. Further interview revealed the LPN informed the CNAs on February 20, 2011, that a lift was to be utilized for resident #1 when transferring the resident for bathing. The LPN also informed the Director of Nursing (DON) that staff was not utilizing the lift on February 21, 2011. An interview conducted with the Director of Nursing (DON) on March 23, 2011, at 3:15 p.m., revealed resident #1 was assessed to require the use of a mechanical lift for all transfers because of the resident's severe osteoporosis. The DON stated the nurses were required to monitor resident baths daily when making rounds to ensure the care was provided according to the resident's plan of care. Further interview revealed the CNAs were checked off on bathing and transfers by a preceptor upon hire and annually to ensure the CNAs were knowledgeable regarding	F 282		

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F 282	Continued From page 4 resident care. The DON was not aware staff was not utilizing the Hoyer lift to transfer resident #1 for bathing per the resident's plan of care until February 21, 2011. Resident #1 sustained a fractured tibia and fibula during this incident according to the facility investigation.	F 282		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure one of three sampled residents (resident #1) received adequate supervision and assistive devices to prevent accidents. The facility assessed resident #1 to require the use of a Hoyer lift for all transfers. However, staff transferred resident #1 without the use of a Hoyer lift on February 20, 2011. The resident complained of right knee pain during the transfer, and was diagnosed with a fracture to the tibia and fibula (below the right knee) on February 22, 2011. Review of the resident's medical record and staff interview revealed staff was required to utilize a Hoyer lift when transferring resident #1 to ensure safe transfers for this resident. The findings include:	F 323	1. Resident #1 received treatment at the hospital upon verification of the x-ray results. An investigation into the circumstances of the injury to Resident #1 was conducted by the Administrator and DON upon identification of the injury findings, with notification of DCBS and the OIG. Review of the status of Resident #1 was conducted with the family, with review/revision of the care plan and patient record to include bed baths for bathing and mechanical lift for all transfers. 2. All residents requiring the use of a mechanical lift have been evaluated to determine appropriate lift use. Findings were reviewed with the residents/ families with review/revision of the care plans and patient care records to address lift use as indicated. 3. Licensed and non-licensed nursing staff have received in-service education on the provision of transfer assistance for residents in accordance with the care plan and patient care record, including but not limited to the proper use of the mechanical lift, as provided by the DON/ ADON/Staff Development on 2/24, 3/2, 3/7, 3/16, 3/21, 3/23, 3/24, 3/25, 3/26, 3/27, 3/28, 3/30, 3/31, and 4/6.	4/8/11

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F 323	Continued From page 5 Review of the medical record for resident #1 revealed the resident was admitted to the facility on October 6, 2004, with diagnoses that included severe Osteoporosis, Osteoarthritis, a history of Fractured Vertebrae, and Lumbar Compression. A review of a Minimum Data Set (MDS) for resident #1 dated April 8, 2010, revealed the facility assessed the resident to require total assistance of two or more staff persons for transfers. A review of the care plan for resident #1 revealed an intervention for the use of a mechanical lift dated April 5, 2010, and that a gait belt assisted transfer had been discontinued from the care plan on June 29, 2010. A review of the physician's orders for February 2011 revealed a mechanical lift was to be utilized for all transfers for resident #1. A review of nurse's notes for resident #1 revealed on February 22, 2011, at 12:45 p.m., resident #1 was noted to be in pain and was noted with redness and edema to the right leg and right knee. The nurse's notes stated resident #1 was transferred to the hospital for evaluation and treatment. Resident #1 returned to the facility on February 22, 2011, at 4:30 p.m., with a diagnosis of fracture to the bones in the right leg. Review of the facility investigation completed on February 25, 2011, revealed the fractures to resident #1's right leg were determined to be caused when resident #1 was transferred by CNAs #1, #2, and #3 without the use of a Hoyer lift during a bath on February 20, 2011. Interview conducted with the Advanced Registered Nurse Practitioner (ARNP) on March 24, 2011, at 11:00 a.m., revealed if the	F 323	4. Observations of non-licensed nursing staff implementation of interventions in accordance with the care plan/patient record will be completed by the DON/ADON/Staff Development Coordinator on 2 staff per day x 1 week, then 2 staff per week x 2 weeks, and then using the CQI Indicator as outlined. The CQI Indicator for the monitoring of implementation of interventions in accordance with the care plan/patient care record will be utilized monthly x 2 months, and then quarterly as per the established CQI calendar, under the supervision of the Director of Nursing.	

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F 323	Continued From page 6 mechanical lift had been utilized to transfer resident #1 the resident would have been less likely to have been injured. The ARNP stated the use of the mechanical lift would have applied more even pressure during the transfer. Per interview, it would be difficult for three staff persons to lift a resident with even pressure because staff could not lift at the exact same time. An interview conducted with CNA #1 on March 23, 2011, at 2:35 p.m., revealed on February 20, 2011, CNA #1 assisted CNAs #2 and #3 with the transfer of resident #1 from a geri-chair to a bath/lift chair. CNA #1 stated resident #1 complained during the transfer by saying, "Oh, my knee." However, resident #1 did not complain at any other time during care or when the resident was transferred back to the geri-chair after the bath was completed. CNA #1 was aware that resident #1 required a Hoyer lift for transfers. However, CNA #1 stated resident #1 was always transferred for bathing with the use of a gait belt and three staff persons. An interview conducted with CNA #3 on March 23, 2011, at 2:48 p.m., revealed CNA #3 was primarily responsible for resident bathing. CNA #3 provided a bath to resident #1 on February 20, 2011, and had transferred resident #1 with the assistance of CNAs #1 and #2. CNA #3 stated a gait belt was utilized to provide a sitting transfer from a geri-chair to a bath/lift chair for resident #1 on February 20, 2011, without the use of a Hoyer lift. CNA #3 was aware that resident #1 was assessed to require the use of a Hoyer lift for all transfers. However, a Hoyer lift had never been used to transfer resident #1 during bathing according to CNA #3. In addition CNA #3 stated	F 323		

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F 323	Continued From page 7	F 323		

that resident #1 had always been transferred with the use of three staff persons and a gait belt. CNA #3 further stated a lift could be utilized, but the shower room was small. However, CNA #3 stated the concern regarding the shower room size had not been reported to the facility's administrative staff.

An interview conducted with CNA #2 on March 23, 2011, at 3:06 p.m., revealed on February 20, 2011, CNAs #1, #2, and #3 transferred resident #1 from a geri-chair to a bath/lift chair utilizing a gait belt. CNA #2 stated when resident #1 was turned during the transfer resident #1 said, "Oh, my knee." CNA #2 stated resident #1 had no further complaints after the transfer, during the bath, or when transferred after the bath was completed. CNA #2 stated a Hoyer lift had never been utilized for resident #1 during bathing transfers.

An interview conducted with LPN #1 on March 23, 2011, at 1:50 p.m., revealed resident #1 was assessed to require a lift for transfers because the resident was heavy and pulling on the resident could cause injury to the resident. Further interview revealed the LPN was required to make rounds each shift to ensure the CNAs were providing resident care as required. However, the LPN was not aware staff was not utilizing a lift to transfer resident #1 for bathing. LPN #1 became aware staff was not utilizing a lift for transfers during bathing on February 20, 2011, when the CNAs requested that an order be obtained for showers for resident #1 instead of a tub bath because of the resident's size. LPN #1 informed the CNAs that a lift was to be utilized to transfer resident #1 for bathing. The LPN informed the Director of Nursing (DON) that staff

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F 323	Continued From page 8 was not utilizing the lift on February 21, 2011. An interview conducted with the Director of Nursing (DON) on March 23, 2011, at 3:15 p.m., revealed the nurses at each station were required to make rounds daily to monitor resident care and to ensure that CNAs were providing resident care as ordered/planned. The DON stated the CNAs were checked off by a preceptor for resident bathing and transfers upon hire and annually to ensure the CNAs were knowledgeable regarding resident care. The DON was not aware staff was not following the care plan for resident #1 by utilizing a Hoyer lift for all transfers, until LPN #1 informed the DON that the CNAs had not used a lift for resident #1 on February 20, 2011. An interview conducted with the facility Administrator on March 23, 2011, at 5:15 p.m., revealed facility administrative staff made rounds on all stations daily to ensure care provided to residents was appropriate. The Administrator stated administrative staff and nurses monitored resident bathing. However the Administrator was not aware staff had not utilized the use of a Hoyer lift while transferring resident #1 to ensure safe transfers. Resident #1 sustained a fractured tibia and fibula during this incident according to the facility investigation.	F 323		